INSURANCE

DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF ANTI-FRAUD COMPLIANCE

DEPARTMENT OF LAW AND PUBLIC SAFETY
OFFICE OF INSURANCE FRAUD PROSECUTOR

Fraud Prevention and Detection Plans
Insurer Reporting Requirements to Office of Insurance Fraud Prosecutor

Joint Proposed Repeals: N.J.A.C. 11:16-4, 5 and Appendix A

Joint Reproposed New Subchapter: N.J.A.C. 11:16-6

Authorized By: Jaynee LaVecchia, Commissioner, Department of Banking and Insurance and John J. Farmer, Jr., Attorney General of New Jersey

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17:23-8 et seq., 17:23-19, 17:23-20, et seq., 17:33A-1 et seq., 47:1A-2, Executive Reorganization Plan No. 7 (1998) and Executive Order No. 9 (Gov. Richard J. Hughes, September 20, 1963).

Proposed Number: PRN 1999-397

Submit comments by December 1, 1999 to

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The agencies reproposal as follows:

Summary

These new rules were originally proposed on May 17, 1999 at 31 N.J.R. 1257(a).

Thirty one letters of comment were received by the Department of Banking and Insurance in response to the proposal. Letters were submitted by:

Selective Insurance Company of America
American General Life Insurance Company
First Trenton Companies
Coalition Against Insurance Fraud (CAIF)
Parkway Insurance Company
Allstate Insurance Company
Northwestern Mutual Life
Atlantic Mutual Companies
Garden State Hospitalization Plan
Linwood Chiropractic Center
Liberty Mutual
National Association of Independent Insurers (NAII)
Delta Dental
Prudential
AIG
Motor Club of America
State Farm Insurance Companies
American Insurance Association (AIA)
National Health Care Anti-Fraud Association (NHCAA)
Great-West Life & Annuity Insurance Co.
Insurance Council of New Jersey (ICNJ)
New Jersey Board of Medical Examiners
New Jersey Manufacturers Insurance Companies
Health Insurance Association of America (HIAA)
Integrity Plus
Lancer Insurance Company
The Robert Plan New Jersey
Standard Insurance Company
CIGNA
AmeriHealth Insurance Company of New Jersey
Principal Financial Group

A summary of comments and the responses by the Department of Banking and Insurance ("DOBI") and the Office of the Insurance Fraud Prosecutor ("OIFP") appear at the end of this Summary because this is a reproposal and many of the changes are as a result of the comments submitted in response to the initial proposal.

These rules were initially proposed in response to recent amendments to N.J.S.A. 17:33A-15 (P.L. 1997, c.151) and the enactment of N.J.S.A. 17:33A-16 et seq. (P.L. 1998, c.21 and 22) (hereinafter referred to as the "Acts") which require significant changes in the administrative rules governing an insurer's anti-fraud investigation and reporting activities. It was also noted that N.J.A.C. 11:16-4 and 5 are extremely similar and apply many of the same obligations to private passenger auto insurers and health insurers. As a result, DOBI has determined that it is reasonable to combine all these anti-fraud initiatives into one new subchapter. This will necessitate the repeal of the currently existing N.J.A.C.

11:16-4, 5 and Appendix A and adoption of a new subchapter to be known as N.J.A.C. 11:16-6, Fraud Prevention and Detection Plans. This new subchapter will combine many currently existing rules without significant change and will introduce several new rules required by the Acts. The reproposed new subchapter will achieve the following:

- consolidate the obligations previously contained in subchapters 4 (private passenger automobile insurance) and 5 (health insurance);
- set forth the reporting requirements and forms necessary to report to OIFP;
- provide for the development and contents of an insurer's fraud prevention and detection manual;
- establish the standards for review of an insurer's manual by DOBI's Division of Anti-Fraud Compliance ("DAFC");
- require entry level and continuing education programs for claims, SIU and underwriting personnel;
- establish staffing composition of an SIU;
- permit insurers to employ SIU professionals and SIU specialists where appropriate; and
- establish the standards for referral of cases of suspected fraud to OIFP.

Prior to the Acts, insurers were only required to report cases of fraudulent claims to DOBI. Hereafter, in accordance with the Acts and this subchapter, insurers will be required to take active measures to confront and report not only claims fraud but also application fraud. While insurers will continue to be required to have a special investigative unit ("SIU") for the detection and prevention of claims fraud, the SIU will now be required to address application fraud as well. The composition of SIUs has been enlarged to include SIU specialists, when needed, and special training in claims and application fraud will be required for all SIU, claims and underwriting personnel. Insurers continue to be required to promulgate an insurance fraud prevention and detection manual in conformance with these rules, which will be audited by the DAFC. These performance audits may be conducted on site at the insurer's main office or SIU, and are intended to ensure that the fraud prevention and detection plan is being complied with in all material respects. In addition to performance audits, the DAFC will also develop and present training programs.

OIFP, which is established in the Division of Criminal Justice in the Department of Law and Public Safety, is under the supervision of the Attorney General. The creation of OIFP represents a recognition of the malignant effect insurance fraud has on the State's economy and the commitment of this State to use the full weight of law enforcement in the effort to investigate and punish violators. The duties and responsibilities of OIFP are found at N.J.S.A. 17:33A-19 and include the obligation to work with DOBI, the Department of Health and Senior Services, the Professional Boards of the Division of Consumer Affairs and other law enforcement agencies to formulate rules and strategies to confront and punish all forms of insurance fraud.

This reproposed subchapter is part of that collaborative effort between DOBI, the DAFC and OIFP in which the offices are jointly promulgating rules to identify those matters that must be reported to OIFP by SIUs and the forms to be used for that purpose. A reproposal is being pursued in order to draw upon the rulemaking authority of both the Attorney General as well as DOBI in promulgating a comprehensive regulatory scheme. The reproposal incorporates both significant and minor changes in response to the public comments to the prior proposal. It also includes a new provision relating to the confidenti-

ality of records and information in the possession of OIFP. The reproposal also contains a new provision requiring insurers to submit within 120 days after adoption a new fraud plan that reflects the requirements proposed herein. DOBI has also significantly modified N.J.A.C. 11:16-6.8 regarding the record retention requirements by also proposing the use of form DAFC #1 to report annually certain information outlined on the form. A further goal of the reproposal is to ensure that all of the pertinent regulatory requirements take effect at the same time and are codified in the same chapter of the Administrative Code.

New provisions are offered to achieve the following purposes:

The proposed rules will provide that cases referred to OIFP will include the following: (a) a brief summary of the facts and circumstances developed by the SIU which leads to a reasonable suspicion that a violation of the Act has occurred; (b) some evidence which corroborates the facts and circumstances as identified by the SIU, and which leads to a conclusion that the Act has been violated; and (c) the identification of the specific records and documents which reflect the suspect insurance claim or application, together with all supporting documentary evidence to include the insurance identification card, Affidavit of Vehicle Theft, receipts, claim checks, etc., all of which will ordinarily be in the possession of the insurer.

While referrals from insurers which include the above elements should be more complete than previously provided, further investigation by OIFP will be required to insure the State can meet the civil and criminal burdens of proof at trial for civil fraud litigation or criminal prosecutions. OIFP projects that this will result in criminal convictions, professional license disciplinary actions, restitution to insurers and others and substantial civil insurance fraud fines and penalties. To implement the reporting obligation, OIFP has developed forms that are found in the Appendix to the new subchapter.

Proposed N.J.A.C. 11:16-6.1 sets forth the purpose and scope of the subchapter and combines many of the requirements in N.J.A.C. 11:16-4.1 and 5.1.

Proposed N.J.A.C. 11:16-6.2 sets forth the definitions to be used in the implementation of the subchapter. These definitions include “application,” “Commissioner,” “DAFC,” “department,” “eligible person,” “fraud and misrepresentation,” “fraud prevention and detection plan,” “health insurance,” “insured lives,” “insurer,” “OIFP,” “special investigations unit” and “stop loss or excess risk insurance.” Some of these definitions are taken from N.J.A.C. 11:16-4.2 and 5.2 which will be replaced by the new subchapter.

Proposed N.J.A.C. 11:16-6.3 contains the general requirements to be followed by insurers when filing their fraud prevention and detection plans with DOBI and finds much of its origin in N.J.A.C. 11:16-4.3 and 5.3.

Proposed N.J.A.C. 11:16-6.4 contains the duties, qualifications and composition of an insurer's special investigations unit which, in part, is currently in N.J.A.C. 11:16-4.4 and 5.4.

Proposed N.J.A.C. 11:16-6.5 establishes the required elements of an insurer's manual as well as the training programs to be provided to SIU, claims and underwriting personnel on an entry level and continuing education basis. Part of this obligation previously existed in N.J.A.C. 11:16-4.4(c) and 5.5(c).

Proposed N.J.A.C. 11:16-6.6 and 6.7 establish the insurer's obligation to refer certain information about suspicious applications and claims to OIFP which must be referenced in the Insurer's Fraud Prevention and Detection Plan. This section references certain OIFP-developed forms, contained in the subchapter Appendix, which are to be used by insurers in reporting cases to OIFP. These sections replace N.J.A.C. 11:16-4.4(e), 5.4(b), (c) and (e), and Appendix A.

Proposed N.J.A.C. 11:16-6.8 imposes record retention requirements on insurers.

Proposed N.J.A.C. 11:16-6.9 contains the rules for filing and approval of fraud prevention and detection plans. This proposed rule also provides for the confidentiality of information included in an insurer's fraud plan submitted to the DAFC. These rules replace N.J.A.C. 11:16-4.3(c) and 5.5(a).

Proposed N.J.A.C. 11:16-6.10 provides for the imposition of penalties in accordance with N.J.S.A. 17:33A-15, for failure to comply with the requirements set forth in this subchapter and will take the place of N.J.A.C. 11:16-4.7 and 5.7.

Proposed N.J.A.C. 11:16-6.11 provides a new requirement that all insurers must file with DOBI a new fraud prevention and detection plan within 120 days following the adoption of this Subchapter.

In furtherance of N.J.S.A. 17:33A-11, OIFP proposes a confidentiality provision, N.J.A.C. 11:16-6.12, as part of this reproposal to identify the types of records maintained by OIFP which are deemed confidential and the terms upon which these records may be shared with other agencies.

To address a number of the issues raised by the commenters, the agencies hereby issue a joint reproposal. By issuing this joint reproposal, the agencies recognize that a united effort between DOBI and OIFP is essential to achieving this State's commitment to "confront aggressively the problem of insurance fraud." It will also aid the regulated community by codifying the relevant rules regarding insurance fraud in one place in the Administrative Code.

The reproposed new rules provide that OIFP must be advised of all types of insurance fraud matters, thereby clarifying the applicability of the referral and notification provisions found in N.J.A.C. 11:16-6.6 and 6.7. The referral and notification provisions will extend to all insurance companies as defined by N.J.S.A. 17:33A-3, not merely to health and automobile insurers. Only health and automobile insurers will be required to submit fraud prevention and detection plans. The reproposed new rules further take into consideration the comments received about the form and content of the referral and notification forms. As a result, OIFP has modified the Claims Fraud Referral Form (OIFP-1A), the Application

Fraud Referral Form (OIFP-1B) and the Suspicious Claim/Application Notification Form (OIFP-2, formerly designated OIFP-3), which are set forth in the Appendix hereto. The reproposed new rules eliminate the Pattern Referral Form (formerly OIFP-2). Carriers may advise OIFP of the existence of a pattern using the reproposed referral and notification forms. The reproposed new rules also address concerns raised about the notification provision of the original proposed rules.

The reproposed new rules further provide insurers with the ability to set forth criteria in their fraud plans to identify what types of application fraud referrals will be made to OIFP. The criteria suggested by the insurers will be subject to the approval of OIFP, and by DOBI through its responsibility to approve fraud plans pursuant to N.J.A.C. 11:16-6.9.

DOBI received a number of comments in response to its May 17, 1999 proposal regarding this subject. What follows is a summary of the comments and DOBI's and OIFP's responses thereto.

Comment: A number of commenters submitted letters indicating that it is inappropriate for insurers to be solely responsible for initiating criminal and/or civil insurance fraud actions.
In its comments regarding the referral forms, one commenter noted that the referral forms do not refer to violations of the Health Care Claims Fraud Act and the Workers' Compensation Fraud Act.

Response: The agencies agree with the commenters. It is the industry's responsibility to refer matters in accordance with N.J.A.C. 11:16-6.6(b) and 6.7. After receiving and reviewing referrals from the industry, OIFP will be responsible for evaluating the referrals and pursuing those which are deemed appropriate for criminal prosecution and/or civil action. OIFP will also determine the appropriate statute to be employed in pursuing a criminal fraud matter. Therefore, no reference on the referral forms to the Health Care Claims Fraud Act or the Workers' Compensation Fraud Act is necessary.

Comment: Some commenters have requested that the term "reasonable suspicion" as used in N.J.A.C. 11:16-6.7 be defined.

Response: The term "reasonable suspicion" has long been used in statutes, regulations and case law and should therefore be accorded its standard meaning. When submitting referrals to OIFP, the carriers must identify specific and articulable facts that, taken together with rational inferences from those facts, reasonably support a conclusion that a violation of the Insurance Fraud Prevention Act has occurred. To assist the carriers in understanding what constitutes a reasonable suspicion, the agencies anticipate providing training regarding standards for the submission of referrals to OIFP.

Comment: Many commenters expressed concern about proposed N.J.A.C. 11:16-6.4(b)4 which requires carriers to maintain a database of fraudulent claims including names, addresses, and identifying information concerning all parties to an SIU investigation. The proposal provides that said database is to be made available to DAFC and OIFP.

Some commenters have raised an additional concern regarding the extent of the immunity afforded to carriers when the DAFC and OIFP gain access to carriers' fraud databases which contain sensitive, trade secret and proprietary information.

One commenter asked for clarification of the definition of a fraudulent claim as contemplated for input into the database and the length of time a record of the claim must remain in the database.

Response: The agencies evaluated the commenters' letters and have concluded that neither DOBI nor OIFP needs direct access under the Acts to the insurers' fraudulent claims database. However, insurers must maintain such a database to facilitate the retrieval of information necessary for the insurer to comply with its referral and notification obligations and other reporting requirements. In accordance with N.J.S.A. 17:33A-23, at the request of the Insurance Fraud Prosecutor, any insurer which has referred a matter to OIFP or to any county or local government agency shall make available to OIFP all information relevant to the matter in the insurer's possession. Pursuant to N.J.S.A. 17:23-20 et seq., N.J.S.A. 17:33A-15, and other authority, DOBI has broad access to insurer books, records, accounts, papers, documents, computer records and other recordings. Therefore, the reference to DOBI's and OIFP's access to the insurers' fraudulent claims database in N.J.A.C. 11:16-6.4(b)4 has been eliminated.

Comment: A few commenters have recommended that a common format be required for the fraudulent claims database to facilitate the sharing of information. Some commenters requested that OIFP share information in its database with insurance carriers.

Response: OIFP anticipates promulgating rules in connection with the all claims database mandated by N.J.S.A. 17:33A-22b in the future.

Comment: A number of commenters recommend that OIFP provide for the submission of referrals electronically to increase efficiency of reporting.

Response: OIFP appreciates the commenters' suggestions for facilitating the process of transmitting information to OIFP. However, OIFP currently lacks the technological capability to permit large-scale electronic transfer of data. OIFP is in the process of establishing its computer system and intends to implement electronic reporting at a future time when such reporting may become feasible.

Comment: Several commenters advocate that instances of health insurance fraud involving providers be referred using a "case" approach rather than a "claim" approach. The rationale set forth for the "case" approach is based on the unique nature of health insurance fraud. A significant portion of suspected health care claims fraud may involve one provider submitting a large number of claims. Because of the sheer volume of individual claims, referrals based on each claim would be burdensome and unmanageable.

Response: OIFP accepts the commenters' suggestion to consider the referral of provider driven health care claims fraud using a "case" approach as opposed to a "claims" approach. In these types of referrals, the provider should be identified as the subject on the Claim Fraud Referral Form OIFP-1A and patients and/or others who are acting in concert with the providers should be listed as additional subjects. In addition, for each "case" involving a provider, carriers should identify all claims and the corroborating evidence which meets the standards for referral in N.J.A.C. 11:16-6.7. It is imperative that OIFP be provided with all relevant information about each claim, including the amount of the claim (whether or not paid), the reason(s) the claim is suspected to be fraudulent, the evidence that corroborates the belief that the claim is fraudulent, etc., because under State law a criminal prosecution of a

provider generally must proceed on a claim by claim basis. Further, OIFP, through its industry liaison, is willing to address the carriers' specific questions about provider referrals as the need arises.

Comment: In its comment to the proposal, the New Jersey State Board of Medical Examiners reminds OIFP that immediate referrals to the Board of Medical Examiners are essential in cases where referrals received from carriers include information that patients are being placed at risk by the actions of Board licensees.

Response: OIFP acknowledges the Board's interest in protecting the public health and welfare. N.J.S.A. 17:33A-18 mandates that OIFP establish a liaison between OIFP and any professional board in the Division of Consumer Affairs in the Department of Law and Public Safety. In accordance with this provision, a liaison has been established to ensure prompt and continued notification to the Division of Consumer Affairs and to foster cooperative investigations in all cases involving Board licensees.

Comment: A number of commenters questioned the applicability of these rules to insurers writing insurance other than health and private passenger automobile. One commenter questioned whether the proposed rules apply to the Personal Automobile Insurance Plan (PAIP) or the Commercial Automobile Insurance Plan (CAIP).

Response: These proposed rules set forth the criteria for referrals of fraudulent claims and applications and notification of suspicious claims and applications to OIFP. All insurers are subject to these requirements. The Insurance Fraud Prevention Act and the amendments thereto embodied in the Automobile Insurance Cost Reduction Act (AICRA) empower OIFP to investigate and prosecute cases involving any type of claim or application fraud committed against any insurer as defined in N.J.S.A. 17:33A-3. The obligation for PAIP and CAIP to comply with these rules is carried out through the assigned carriers, and not the PAIP or CAIP directly.

N.J.S.A. 17:33A-15 requires every insurer writing health or private passenger automobile insurance in this State to file with the Commissioner of the DOBI a plan for the prevention and detection of fraudulent insurance applications and claims. These proposed rules are meant to govern, among other things, the content of fraud prevention plans to be submitted by health or private passenger automobile insurers contemplated by N.J.S.A. 17:33A-15.

Therefore, the agencies issue this joint reproposal to clarify that elements of proposed N.J.A.C. 11:16-6.6 and 6.7, regarding the referral of cases of fraudulent applications and claims and notification of suspicious claims and applications to OIFP, will apply to all insurers as defined by N.J.S.A. 17:33A-3, and does not include the PAIP or CAIP.

Comment: A number of commenters submitted letters disagreeing with the number and content of the forms proposed for use when insurers refer application or claims fraud to OIFP or notify OIFP of suspicious claims or applications. Many commenters stated that the forms were complex, time-consuming, duplicative and burdensome. A few requested that the referral form be limited to one page. Some commenters questioned whether they had to include information on providers who are not subjects of the investigation.

Response: OIFP emphasizes that there is a fundamental need for thorough and accurate reporting of information to OIFP to assist in the successful identification, investigation and prosecution of insurance fraud. All of the information included on OIFP referral and notification forms is integral to OIFP's evaluation of the referral or notification. OIFP feels that a one page referral or notification form provides insufficient information to evaluate a referral. However, OIFP is not indifferent to the carriers' administrative concerns. Therefore, the following changes have been made to the forms in the Appendix of the proposed rules and the new forms are hereby made part of DOBI's and OIFP's joint proposal.

Claim Fraud Referral Form OIFP-1A. Part One of this form requires the carrier to provide basic information about the fraudulent claim such as the claim and policy numbers, the amount of the claim and whether it has been paid. Part Two requires the carrier to identify the specific provision of the Insurance Fraud Prevention Act which was violated by checking the appropriate box. Part Three requires the carrier to identify 1) the suspicious facts which may indicate a violation of law, 2) the false or misleading statements made to the carrier, or information omitted in the claim, 3) the evidence which corroborates the suspicious facts identified as the basis for the violation, and 4) whether a licensed professional knowingly participated in the fraud. Part Four of the referral form requests basic information about additional subjects, if any, of the investigation. The last part of the referral form requests basic information about licensed professionals, if any, who are subjects of the investigation.

Application Fraud Referral Form OIFP-1B. This form requires the carrier to provide basic information about the fraudulent application, to identify the specific provision of the Insurance Fraud Prevention Act which was violated by checking the appropriate box and to identify 1) the suspicious facts which may indicate a violation, 2) the false or misleading statements made to the carrier, or information omitted in the application and 3) the evidence which corroborates the suspicious facts identified as the basis for the violation. This form also requires the carrier to identify whether an insurance producer or insurance agency employee knowingly participated in the fraud.

Proposed Pattern Notification Form OIFP-2. This form has been eliminated. Cases involving a pattern may be identified by checking the appropriate box on the Claim Fraud Referral Form OIFP-1A or the Suspicious Claim/Application Notification Form OIFP-2 (originally designated in the proposal as OIFP-3). Also, the industry is encouraged to directly contact OIFP through its industry liaison to arrange a meeting to discuss any matter that appears to involve a pattern of suspicious claims or applications.

Notification Form OIFP-2 (originally designated as OIFP-3). Part One of the notification form requires the carrier to provide basic information about a suspicious claim. Part Two requires the carrier to identify the specific provision of the Insurance Fraud Prevention Act which may have been violated by checking the appropriate box. Part Three requires the insurer to identify the suspicious facts, any statements suspected to be false or any relevant information suspected to have been omitted from a claim or application, and to identify any licensed professional suspected to have knowingly participated in violating the law. Part Four of the notification form requests basic information about additional subjects, if any, of the investigation. The last part of the notification form requests basic information about licensed professionals, if any, who are subjects of the investigation.

The agencies anticipate providing training in connection with the referral/notification provisions of the proposed rules. Moreover, OIFP, through its industry liaison, will answer questions about particular referrals as the need arises.

Comment: One commenter expressed concern about the applicability of the referral rules in cases where an insurer is working with the Federal government in a fraud matter.

Response: OIFP recognizes that there may be occasions when an insurer is providing information to the Federal authorities in connection with an investigation. However, insurers are required to advise OIFP of any matters meeting the referral or notification criteria set forth in N.J.A.C. 11:16-6.6 and 6.7, even if those matters are currently under review by Federal authorities.

Comment: A number of commenters expressed concern about notifying OIFP about claims or applications which do not rise to the level of a referral, that is, where there is insufficient evidence to corroborate the suspicion that a violation has occurred. The commenters perceive potential exposure to claims of libel and bad faith. The commenters object to the use of the notification form.

In addition some commenters seek a definition of the term "fraud factors" as used in N.J.A.C. 11:16-6.6(c) to identify when use of the Notification Form #OIFP-2 (formerly designated as OIFP-3) is appropriate.

Response: OIFP disagrees with the commenters who wish to eliminate the Suspicious Claim/Application Notification Form OIFP-2 (formerly designated OIFP-3). OIFP feels that the Notification Form is an important tool in analyzing suspicious claim/application data, developing investigative leads and identifying fraud trends. OIFP recognizes that there may be instances where an investigation is terminated by the insurance carrier before corroborative evidence to support a case referral is developed. For example, a claim may be resolved because one of the contractual provisions in the insurance policy was not met or because the claimant withdraws the claim or cancels the policy of insurance. In these types of situations, OIFP feels that notification of suspicious claims and applications is essential to addressing fraud because it provides OIFP with information to investigate the matter when OIFP concludes further investigation is warranted.

Further, pursuant to N.J.S.A. 17:33A-9b, a person filing reports or furnishing other information under the Act is entitled to qualified immunity for libel, violation of privacy or otherwise so long as the information was provided in good faith and without malice and it was required by OIFP as a result of the authority conferred upon it by the law. Thus, in instances where the Notification Form OIFP-2 is submitted, N.J.S.A. 17:33A-9b provides protection from liability if the information was provided in good faith and OIFP has required its submission. Insurers are similarly protected from civil liability by N.J.S.A. 17:23-15.

Nevertheless, OIFP recognizes the sensitive nature of information contained in notifications of suspicious claims/applications where corroborating evidence has not been obtained. The Legislature has recognized the need for confidentiality to promote the effective investigation and prosecution of insurance fraud. N.J.S.A. 17:33A-11 provides that papers, documents, reports or evidence relative to the subject of an investigation under the Insurance Fraud Prevention Act are not subject to public inspection or

subpoena. Therefore, a confidentiality provision is proposed in connection with the reproposal of these rules.

With respect to a definition of the term "fraud factors," OIFP notes that this term has been part of this regulatory scheme for many years. Further, this is a term commonly used in the industry and should, therefore, be afforded its standard meaning.

Comment: One commenter recommended that OIFP-1B form for referral of application fraud include a line for the policy number, if one has been assigned.

Response: OIFP agrees with the proposed change and a line for the policy number (if issued) has been added to Referral Form OIFP-1B.

Comment: Some commenters have raised the issue of the timing of providing information to OIFP. These commenters suggest that there may be instances where the insurer wishes to report suspected fraud prior to obtaining corroboration required in N.J.A.C. 11:16-6.7(c).

Response: OIFP agrees that there may be instances where a case should be brought to the attention of OIFP prior to the completion of the investigation. In those cases where the carrier concludes that a pre-referral notification is appropriate, the carrier should contact OIFP's industry liaison. In situations deemed appropriate for notification prior to the conclusion of the investigation, the carrier may submit information to OIFP on the proposed Suspicious Claim/Application Notification Form OIFP-2 (previously designated OIFP-3). However, notification prior to the conclusion of the investigation does not exempt the carrier from providing the appropriate referral to OIFP on the OIFP-1A or OIFP-1B form assuming that, at the conclusion of the investigation, sufficient corroborative evidence has been developed to warrant a referral.

Comment: Two commenters are concerned with the requirement that, for purposes of referral to OIFP, an investigation is deemed complete when all reasonable and appropriate investigative leads and opportunities have been exhausted. One commenter feels this is expansive and would require an insurer to undertake all investigative responsibilities. One of these commenters further stated that insurers do not have sufficient staff to accomplish this. Both commenters expressed concern that law enforcement officials would find this unacceptable.

Response: OIFP disagrees with the commenters. As indicated previously, OIFP requires that matters be referred when there is evidence which corroborates that a violation of the Insurance Fraud Prevention Act has occurred. Therefore, an investigation is complete when the carrier can identify the suspicious facts or circumstances evidencing the violation, the specific false and misleading statements or the omissions in the claim or application, and some evidence which corroborates the suspicious facts identified as the basis for the violation. As noted in a previous response, there may be circumstances when the carrier may notify OIFP about a particular investigation prior to its completion. The agencies anticipate providing training to assist the carriers in determining when a pre-referral notification is warranted.

Comment: Several commenters have requested that OIFP provide guidelines for the referral of application fraud cases. Some have recommended that OIFP establish a reporting threshold which would warrant a referral. Others have recommended against referral of cases where the carrier has the ability to verify the accuracy of the information by utilizing, for example, Motor Vehicle Reports (MVRs), CLUE reports, mileage verification programs, etc. One commenter proposes that OIFP provide specific examples of conduct constituting application fraud.

Response: OIFP references N.J.S.A. 17:33A-4a(4) which sets forth the elements constituting application fraud. These provisions are reproduced on the application fraud referral form. OIFP acknowledges that in certain instances, carriers are capable of identifying incorrect information provided on applications through use of MVRs, CLUE reports and the like and can adjust the premium accordingly. A strict implementation of the application fraud provision of the Insurance Fraud Prevention Act may tax the carriers' resources. There are a number of methods which carriers could employ which would allow them to conserve their resources and focus on more serious instances of application fraud. Accordingly, the agencies jointly propose that carriers set forth criteria in their fraud plans for the referral of application fraud matters to OIFP. The criteria chosen by the carriers will be subject to the approval of OIFP, and by DOBI pursuant to N.J.A.C. 11:16-6.9. In addition, to assist the carriers in the referral of application fraud cases, OIFP anticipates providing training in conjunction with DAFC.

Comment: One commenter has suggested, as a way to lower the cost of insurance for consumers, that OIFP pass along a portion of any fine levied under the Insurance Fraud Prevention Act to the carrier which referred the case to cover all or a portion of the insurer's costs of investigation. In the alternative, this commenter recommends that restitution and recovery of the carrier's investigation costs be included in settlements achieved by OIFP.

Response: With respect to the sharing of fines imposed, N.J.S.A. 17:33A-5 provides that all revenues from civil penalties imposed pursuant to the Insurance Fraud Prevention Act shall be deposited into the New Jersey Automobile Full Insurance Underwriting Association and Market Transition Facility Auxiliary Fund. Therefore, these civil fines cannot be shared with the referring carriers.

OIFP acknowledges that the restitution of fraudulently obtained benefits is an important component of the aggressive pursuit of insurance fraud. N.J.S.A. 17:33A-26 provides that OIFP shall consider the restitution of moneys to insurers and others who are defrauded as a major priority and further provides for the seizure of assets of any person guilty of fraud. OIFP is committed to assisting the carriers in obtaining restitution of fraudulently obtained benefits.

Comment: One commenter suggested that OIFP be required to process files according to time limits set by the rules and should respond to SIUs regarding all referrals.

Response: Based upon the unique circumstances of individual cases, setting a time limit by rule within which OIFP must process referrals made by carriers is impractical. Cases are individual and often have unique investigatory and prosecutorial requirements. Indeed, "processing" a file can entail different requirements for each case which cannot readily be accomplished in fixed time frames. For example, conducting an investigation which results in closing a matter or recommending the entry of a consent order will generally conclude a referral in less time than will conducting a grand jury presentation or

coordinating an undercover investigation. Since it was established, it has been OIFP's practice to respond in a timely manner to all matters received from carriers. OIFP has also established a liaison to the industry to facilitate communications between OIFP and carriers on particular referrals or general inquiries.

Comment: One commenter suggested that New Jersey should enact a criminal statute similar to that in North Carolina law which makes all insurance fraud and related offenses a felony.

Response: Adopting legislation is beyond the scope of DOBI's or OIFP's power in promulgating these regulations.

Comment: One commenter, a hospital service corporation formed pursuant to N.J.S.A. 17:48-1 et seq., objected to its inclusion in the definition of "insurer." The commenter claims that its inclusion will necessitate costly compliance with N.J.A.C. 11:16-6.-4 and 6.5 which is unnecessary since it rarely, if ever, encounters any incident of application or claim fraud.

Response: DOBI does not have discretion to omit a hospital service corporation from the definition because hospital service corporations are included in the definition of insurer at N.J.S.A. 17:33A-3f.

Comment: A dental service corporation organized in accordance with N.J.S.A. 17:48C-1 et seq., commented that the definition of "health insurance" in N.J.A.C. 11:16-5.2 excludes those organizations which are self-funded or provide "administrative services only" ("ASO") contracts. The commenter objects to the proposed definition of "insurer" which would include all dental service corporations without any exception for those that are administrative services only providers.

Response: The agencies note that the definition of dental service corporation is included in the definition of "insurer" at N.J.S.A. 17:33A-3e. DOBI has previously recognized that administrative services only (ASO) claims merely processed by the insurer are not subject to certain requirements of the proposed rules provided that no policy of insurance was in effect.
Accordingly, the prior definition of "health insurance" will be included in this joint proposal to reflect that carriers which provide "administrative services only" services are outside the scope of N.J.A.C. 11:16-6.4 and 6.5. However, ASO providers have an obligation to participate in the anti-fraud effort and are therefore required to submit referrals and notifications to OIFP in accordance with N.J.A.C. 11:16-6.7.

Comment: One insurer expressed confusion regarding the required number of SIU investigators for private passenger automobile insurers in accordance with N.J.A.C. 11:16-6.4(a) and (c)2. N.J.A.C. 11:16-6.4(a) states that all auto insurers-except those with fewer than 1,000 New Jersey automobile insurance policies shall establish a full-time SIU. N.J.A.C. 11:16-6.4(c)2 provides that automobile insurers shall employ at least one SIU investigator or SIU specialist for each 30,000 New Jersey automobile policies serviced. This commenter questioned if automobile insurers are required to employ an SIU investigator where they have 1,000 to 29,000 New Jersey automobile policies.

Response: The level of SIU staffing has been previously addressed by DOBI. See 27 N.J.R. 2583(a), 2584 (July 3, 1995). The requirements under the rule are summarized as follows:

Policies	Lives, Comprehensive Benefits	Lives, Limited Benefits	SIU's Required
Fewer than 1,000	Fewer than 10,000	Fewer than 10,000	0
1,000-30,000	10,000-60,000	10,000-250,000	1
30,001-60,000	60,001-120,000	250,001-500,000	2
ea. Add'l 30,000	ea. Add'l 60,000	ea. Add'l 250,000	1 additional

Comment: Several insurers objected to the provisions of N.J.A.C. 11:16-6.4(c) which requires that SIUs be a separate unit from the claims adjusting and underwriting units within an insurer's table of organization. They also objected to the requirement that SIU's be composed of a required number of investigators and/or specialists. These insurers noted that the size, composition and relationship with other parts of the insurer's business should be an internal matter within the insurer's discretion. The insurers stated that DOBI should establish measurable standards and goals for anti-fraud compliance and not mandate specific duties, responsibilities and composition of SIUs. Thus, DOBI should measure compliance against established performance standards and results not by a head count in the SIU.

One commenter requested that carriers be permitted to refer instances of application fraud through their underwriting departments in addition to the SIUs.

Response: DOBI disagrees with the comments concerning the requirement that the SIU be separate from the claims adjusting and underwriting functions. While DOBI believes that the SIU should work in concert with the claims adjusters and underwriters by providing advice and directing insurance fraud efforts, it also believes that a separate SIU is necessary in order to pursue investigations independent of the claims adjusting and underwriting functions. A "chain of command" separate from the claims and underwriting departments is necessary to ensure that the SIU's goal of investigating and reporting fraudulent claims does not conflict with a claims department's goal of prompt payment or an underwriting department's goal of maintaining business.

Based upon these reasons and the need for accurate record keeping and consistency of reporting, instances of fraud, including application fraud, must be referred through an insurer's SIU.

Comment: Three insurers suggested that the rules do not permit a company to hire an outside contractor to perform its anti-fraud efforts in conformance with these rules. These insurers noted that N.J.A.C. 11: 16-6.9(e) mentions the use of outside agents and contractors to adjust, investigate claims and underwrite policies but does not specifically refer to the use of an outside vendor to perform SIU functions.

Response: DOBI acknowledges that an insurer may use outside vendors to perform SIU functions. Pursuant to newly proposed N.J.A.C. 11:16-6.6(e), insurers will be required to provide in their fraud prevention and detection plans the name and address of all outside vendors used to conduct investigations or perform SIU functions.

Comment: Several commenters objected to the provisions of N.J.A.C. 11:16-6.4(b)9 which would require that the SIU properly rate and/or re-rate all policies and ensure that all premiums are recovered. The commenters stated that it is inappropriate for members of the SIU to instruct members of the underwriting department on the proper rating of policies or to deal with collection of premiums.

Response: DOBI agrees with the commenters that it is not appropriate for the SIU to rate policies or deal with the collection of premiums. Therefore, this reference has been removed from the rule.

Comment: Many commenters expressed concern regarding the training requirements and qualifications of members of the SIU in accordance with proposed N.J.A.C. 11: 16-6.5. The commenters suggested that the following changes be made: 1) reduce the number of training hours; 2) give newly hired SIU members greater time to satisfy the initial training requirements; 3) give newly hired employees credit for previous employment as an SIU investigator; 4) allow credit for self study, computer study, on the job training; 5) provide differentiation between the training for SIU investigators and the training for underwriting and claims employees; 6) define the qualifications of those entities permitted to provide the training; and 7) define classroom instruction to include other methods of instruction. Commenters also felt that training procedures manuals are proprietary in nature and, therefore, companies should only be required to provide summaries of material for inspection.

Response: The agencies feel strongly that fraud training is essential for claims and underwriting personnel as well as SIU staff. Claims and underwriting personnel will be involved in the initial evaluation of claims or applications and will recommend that suspicious claims or applications be referred to the SIU for investigation.

The agencies agree that the proposed 12 hours of instruction per year is reasonable and should not be reduced. The agencies propose to allow insurers to provide basic entry level training to all employees within 120 days from the commencement of their employment, rather than immediately upon hiring as originally proposed. In addition, an employee previously employed as an SIU investigator may be given credit for training which was approved and met the requirement of proposed N.J.A.C. 11:16-6.5. In seeking approval of its training program pursuant to N.J.A.C. 11:16-6.5(a)1, an insurer may propose alternate types of training, such as on-line instruction, subject to the approval of DOBI. The qualifications of those entities permitted to provide training would also be submitted for approval pursuant to proposed N.J.A.C. 11:16-6.5. Therefore, DOBI needs the complete training manual in order to assess the adequacy of the program. Proprietary training manuals would be protected from disclosure pursuant to the confidentiality provision of N.J.A.C. 11:16-6.9(f).

Comment: Several commenters expressed concern about various parts of N.J.A.C. 11:16-6.6. One insurer stated that 60 days to verify underwriting information from the date of receipt of an application is unrealistic. This commenter stated that applicants and other sources of information are occasionally uncooperative and unforeseen events often cause the verification of underwriting data to exceed the 60 day point.

Response: DOBI does not agree with the comments. The 60 days for verification of underwriting information is reasonable and consistent with N.J.S.A. 17:29C-7(B) reted to notice of cancellation of automobile policies. It is recognized that there may be instances where underwriting information may not be verified within 60 days despite diligent efforts of an insurer.

Comment: Several commenters objected to certain provisions of N.J.A.C. 11:16-6.8. One insurer noted that the entire record retention and reporting requirements were too expensive and would not yield any useful data. A number of commenters complained that the filing date of February 1 of each year did not allow sufficient time for insurers to assemble and file their reportable data. One commenter stated that N.J.A.C. 11:16-6.8(b)13, which requires insurers to report the name, address and other important data of those outside agents or contractors used by an insurer to underwrite policies, adjust claims or conduct investigations, is too broad. The commenter notes that insurers use outside agents and companies for many activities and thus reporting of this data is unreasonably broad.

Response: DOBI has considered the comments and is significantly reducing the quantity of the reportable information. The information is of such a nature and type that SIUs should have it readily available and current on a periodic basis. It includes the number of case referred to and processed by the SIU and the dollar amount of any savings realized from these anti-fraud efforts. The reporting date is not being changed since DOBI believes that this streamlined procedure can easily be achieved. DOBI notes that the reporting will be on a new form, DAFC #1, which is being added to the Appendix. Insurers may elect to file electronically by disk or by e-mail to the DAFC's address, which is dafc@dobi.state.nj.us. Also, insurers can obtain the form template on a disk or by e-mail from the DAFC at no cost pursuant to proposed N.J.A.C. 11:16-6.8(b)2 and 3.

DOBI has also modified the requirement regarding the submission of outside vendor data. Insurers are now required to submit in their fraud prevention and detection plans the names and addresses of all vendors used by the insurer to conduct investigations or provide SIU services.

Comment: Three comments were received concerning the provisions of N.J.A.C. 11:16-6.9. One commenter stated that insurers should be able to file amendments to their currently existing Fraud Prevention and Detection Plans rather than filing entirely new plans. Another commenter stated that plans should be deemed approved upon filing unless disapproved by DOBI based upon expressed deficiencies. The final commenter noted that subsection (d) uses the word "examination" to describe the process wherein the DAFC is permitted access to the insurer's office to determine compliance with the fraud prevention and detection plan. The commenter claims that confusion may arise with the provisions of N.J.S.A. 17:23-22 which also uses the word "examination" in regard to the process wherein the Commissioner may conduct an examination of the assets, liabilities and business practices of an insurer's business operations. The commenter suggested that the word "review" should be substituted for the word "examination."

Response: The adoption of these rules will require the carriers to make significant additions or changes to their existing fraud prevention and detection plans. Therefore, DOBI will require that all insurers submit new and comprehensive plans encompassing all of the requirements set forth in these rules within 120 days of adoption of these rules. Finally, DOBI substitutes the term "audit" for the term

"examination" in N.J.A.C. 11:16-6.9 (d) and (e). Regarding the commenters' deemer concerns, DOBI refers to N.J.A.C. 11:16-6.9(c) which states that plans are deemed accepted if not disapproved within 90 days of filing.

Comment: One insurer suggested that automobile insurance policies should be made subject to mid-term cancellation for fraud as part of any anti-fraud effort**.**

Response: DOBI disagrees with this commenter. N.J.S.A. 17:29C-7 provides grounds for cancellation of automobile policies for non-payment of premium or suspension of a driver's license. The Legislature has not included fraud as a basis for mid-term cancellations.

Social Impact

The reproposed subchapter is designed to implement the legislative mandates imposed by the Acts. This subchapter will require insurers to adopt procedures for the detection/prevention of application fraud in health and private passenger automobile insurance; to continue efforts for the prevention/detection of claims fraud; update and amend their fraud prevention and detection manuals; provide training on an entry level and continuing education basis to SIU, claims and underwriting personnel; and report suspected cases of application and claims fraud to OIFP and to cooperate with OIFP and the DAFC in furtherance of these obligations. In helping to discourage fraudulent insurance claims and application, this subchapter will achieve a beneficial social purpose.

Economic Impact

The adoption of this new subchapter will impose economic obligations on insurers to submit new fraud prevention/detection plans and on DOBI to review them; to initiate efforts to identify and remedy application and claims frauds; to provide initial and continuing education programs to underwriting, SIU and claims personnel; to employ sufficient SIU investigations and SIU specialists as are necessary to comply with these rules; and to report suspected cases of application and claims fraud to OIFP. In many cases, the existing rules require similar obligations and, thus, will not require any additional expenditures. In other matters, new expenditures will be required. In either case, the cost of these efforts initially will be borne by DOBI, OIFP and the industry; however, these expenses may be offset by a decrease in claims and application fraud. The agencies also note that in some cases the costs may ultimately be reimbursed by violators.

In addition to the foregoing, it is expected that the anti-fraud efforts of the agencies will have a deterrent effect on unscrupulous medical providers that have abused the health care and PIP medical expense systems with unnecessary diagnostic tests and treatment. This should result in saving to insurers.

Federal Standards Statement

A Federal standards analysis is not required because the reproposed subchapter relates to requirements for filing and review by DOBI of an insurer's fraud prevention and detection plan. These rules relate to health insurance and private passenger automobile insurance fraud prevention and detection plans which are the subject of State law and are not subject to any Federal requirements or standards. The repro-

posed subchapter further sets forth the requirements for submitting a referral or notification to OIFP. These rules relate to the method by which information is provided to OIFP and are also not subject to any Federal requirements or standards.

Jobs Impact

The agencies do not anticipate that any jobs will be lost or gained as a result of the repeal of the two subchapters and the adoption of a new subchapter. The agencies invite commenters to submit any data or studies concerning the jobs impact of this proposed action together with their written comments on other aspects of the new subchapter.

Agriculture Industry Impact

The agencies do not anticipate any impact from the proposed repeals and the new subchapter adoption on the agriculture and related industries in this State.

Regulatory Flexibility Analysis

The reproposed new subchapter will apply to insurers, some of which are small businesses as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

To the extent that the reproposed subchapter will apply to small businesses, they will be required to incur some costs necessary for the development and/or implementation of their fraud detection and prevention plans. Since the underlying legislation which mandates these obligations does not allow for any small business exception in the development of these plans, all companies, regardless of size are required to comply with these requirements. Additionally, all insurers, large and small, are under a continuing obligation to ensure that risks are properly rated and only proper claims are paid and this proposed new subchapter will assist in that effort. Thus, the agencies believe that all insurers regardless of size should be required to comply.

While the agencies are not able to estimate the cost of compliance, any amounts expended for compliance ultimately may be made up by the premium increase resulting from the proper rating of all risks and the money saved by detecting and deterring of payment of fraudulent claims. As a result, no distinction in the application of these rules should or could be made for small businesses.

Full text of the reproposed repeals may be found in the New Jersey Administrative Code at N.J.A.C. 11:16-4, 5 and Appendix A.

Full text of the proposed new rules follows:

SUBCHAPTER 6. FRAUD PREVENTION AND DETECTION PLANS

11:16-6.1 Purpose and scope

(a) This subchapter sets forth the standards for a plan for the prevention and detection of fraudulent insurance applications and claims filed for approval pursuant to N.J.S.A. 17:33A-15 by insurers which transact the business of private passenger automobile insurance or health insurance in this State. These provisions apply to all insurers that transact the business of private passenger automobile insurance in New Jersey, including both personal and commercial coverage; and to all insurers transacting the business of health insurance as set forth in N.J.S.A 17:33A-3 and N.J.A.C. 11:16-6.2.

(b) The subchapter also sets forth the reporting standards and forms necessary to refer insurance fraud matters to the Office of Insurance Fraud Prosecutor ("OIFP"). These provisions apply to all insurers as defined by N.J.S.A. 17:33A-3 and N.J.A.C. 11:16-6.2 including those with PAIP and CAIP assignments.

11:16-6.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Application" means any document that contains the minimum information necessary as set forth at N.J.A.C. 11:3-44.3(a) to determine whether an applicant is an eligible person or is used in any way by the insurer to rate or underwrite a policy, including the coverage selection form and renewal questionnaire as provided at N.J.A.C. 11:3-15.7 and 11:3-8 and, if requested, a copy of the applicant's driver's license, a copy of the motor vehicle registration of the principal vehicle to be insured and any additional proof of New Jersey residency.

The term "application" shall also mean those signed forms, data, reports, analysis and other documents supplied in support of an application when requested by an insurer or by any other person, and/or supplied by the insured/applicant, or other person(s), seeking coverage under a policy or plan of health insurance that is provided to or used by an insurer in assessing the risk, or premium, or which is relied upon by the insurer in agreeing to provide coverage under the policy or plan, including but not limited to that information submitted in accordance with N.J.A.C 11:4-16.7, 11:20-4.1 and 11:21-6.1.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"DAFC" means the Division of Anti-Fraud Compliance in the Department of Banking and Insurance.
"Department" means the New Jersey Department of Banking and Insurance.

"Eligible person" means an individual who meets the qualifications set forth in N.J.A.C. 11:3-34.

"Fraud and misrepresentation" means the knowing misrepresentation of any material fact in a claim or application or the knowing failure to disclose any material fact in a claim or application which, if properly

revealed or disclosed, would change the premium; either would affect the placement or underwriting of the risk, the assignment in the insurer's rating plan, or affect the payment of a claim.

"Fraud prevention and detection plan" or "plan" means an insurer's plan for the prevention and detection of fraudulent insurance applications and claims.

"Health insurance" means a contract or agreement whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disablement, sickness, death by accident or accidental means of a human being, or because of any expense relating thereto, or because of any expense incurred in prevention of sickness, and includes every risk pertaining to any of the enumerated risks. Health insurance does not include any administrative services only (ASO) contracts, workers' compensation coverage, or stop-loss coverage.

"Insured lives" means the actual number of New Jersey residents entitled to receive benefits under a contract delivered or issued for delivery in this State.

"Insurer" means any person or entity authorized to transact the business of private passenger automobile insurance in New Jersey, whether in accordance with a personal lines or commercial lines rating system, and includes a group of affiliated companies, and the Property-Liability Insurance Guaranty Association established pursuant to N.J.S.A. 17:30A-1 et seq. when performing its statutory function.

"Insurer" pursuant to N.J.S.A. 17:33A-3 (health insurance) also means:

1. Any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance pursuant to N.J.S.A. 17:17-1 et seq. or 17B:17-1 et seq.);

2. Any medical service corporation operating pursuant to N.J.S.A. 17:48A-1 et seq.;

3. Any hospital service corporation operating pursuant to N.J.S.A. 17:48-1 et seq.;

4. Any health service corporation operating pursuant to N.J.S.A. 17:48E-1 et seq.;

5. Any dental service corporation operating pursuant to N.J.S.A. 17:48C-1 et seq.;

6. Any dental plan organization operating pursuant to N.J.S.A. 17:48D-1 et seq.

"OIFP" means the Office of the Insurance Fraud Prosecutor in the Division of Criminal Justice in the Department of Law and Public Safety.
"Special Investigations Unit" or "SIU" means the functional group established by an insurer to carry out the duties set forth in N.J.A.C. 11:16-6.4(a).

"Stop-loss or excess risk insurance" means insurance designed to reimburse a self-funded arrangement for catastrophic and unexpected expenses exceeding specified per person retention limits and/or aggregate retention limits, wherein neither the employees nor other individuals are third party beneficiaries under the policy, contract or plan.

11:16-6.3 General requirements and filing format

(a) All insurers shall file for approval a fraud prevention and detection plan ("plan") in accordance with N.J.S.A. 17:33A-15 and this subchapter. No insurer shall use or implement any plan that is not filed and approved.

(b) Insurers shall submit their plan on 8½ by 11-inch paper. The first page shall show the filer's company name, the filer's identifying number for this filing, National Association of Insurance Commissioners ("NAIC") company number(s), and NAIC group number.

(c) Insurers shall file their plan with the Department at the following address:

Fraud Prevention and Detection Plans
New Jersey Department of Banking and Insurance
Division of Anti-Fraud Compliance
PO Box 324
Trenton, N.J. 08625-0324

11:16-6.4 Special Investigations Unit (SIU)-duties, qualifications, and composition

(a) Except for automobile insurers that insure fewer than 1,000 New Jersey automobile policies, and health insurers that insure fewer than 10,000 lives, the plan filed in accordance with N.J.A.C. 11:16-6.3 shall establish a full-time Special Investigations Unit ("SIU").

(b) The SIU shall be responsible for the following:

1. Conducting investigations of claims referred by the claim personnel or applications referred by underwriting personnel whenever the adjuster, processor, or underwriter identifies specific facts and circumstances which, upon further SIU investigation, may lead to a reasonable conclusion that a violation of N.J.S.A. 17:33A-4 has occurred;

2. Providing liaison with OIFP, other law enforcement personnel and the DAFC;

3. Providing in-service training to claims personnel, underwriting personnel, and adjusters in accordance with the provisions of N.J.A.C. 11:16-6.5;

4. Maintaining a database of fraudulent claims and application fraud which shall contain, at a minimum, the names, addresses and other identifying information regarding all parties to the investigation referred to in (b)1 above;

5. Informing insurance underwriters of ineligible risks by reason of prior fraudulent activities from the database in (b)4 above;

6. Identifying persons and organizations that are involved in suspicious claim activity and application fraud, as described in (b)1 above;

7. Referring matters to OIFP in accordance with N.J.A.C. 11:16-6.6(b) and 6.7 and providing notice of suspicious claims in accordance with N.J.A.C. 11:16-6.6(c); and

8. Ensuring that all evidence on matters referred to the SIU including, but not limited to, checks issued in payment of claims, taped statements, original receipts, and original documents submitted by a person or entity in support of or in opposition to a claim applicant, are identified, collected and preserved in order to be turned over to OIFP in connection with the referral of cases to OIFP.

(c) The SIU shall have the following composition:

1. SIU investigators and SIU specialists shall be a separate unit from the claims adjusting or underwriting function.

2. Automobile insurers shall employ at least one SIU investigator or SIU specialist (when permitted by N.J.A.C. 11:16-6.4(d)2) for each 30,000 New Jersey automobile policies serviced.

3. Health insurers offering comprehensive benefits contracts shall employ at least one SIU investigator or SIU specialist (when permitted by N.J.A.C. 11:16-6.4(d)2) for every 60,000 insured lives.

4. Health insurers offering limited benefits contracts shall employ at least one SIU investigator or SIU specialist (when permitted by N.J.A.C. 11:16-6.4(d)2) for every 250,000 insured lives. Limited benefits contracts shall include, but not be limited to, the following: accident only; credit; disability; long-term care; Medicare supplement; dental only; vision only; insurance issued as a supplement to liability insurance; and any other supplemental hospital indemnity benefits.

(d) Qualifications of SIU investigators and specialists shall be as follows:

1. SIU investigators shall have at least one of the following:

i. A Bachelor's degree;

ii. An Associate's degree plus a minimum of two years experience with insurance related

employment;

iii. A minimum of four years of experience with insurance related employment; or

iv. A minimum of five years of law enforcement experience.

2. When approved by the Department in the plan, an insurer shall be permitted to employ a limited number of SIU specialists who shall possess unique qualifications by way of training, technical skill, and/or experience to investigate and identify cases of fraud, but lack the specific educational requirements set forth in (d)1 above, to be SIU investigators.

11:16-6.5 Training program and manual for the prevention and detection of fraud

(a) Except for automobile insurers that insure fewer than 1,000 New Jersey automobile policies and health insurers that insure fewer than 10,000 lives, the plan shall provide anti-fraud education for SIU investigators, SIU specialists, claims adjusters and underwriters that shall include a detailed and comprehensive program of insurance fraud awareness and education to prepare claims adjusting and underwriting personnel for insurance fraud prevention and detection.

1. The training program, which shall include Basic Entry Level Training and Continuing Education Training, shall consist of formal classroom instruction for all adjusters, claims processors, underwriters, SIU investigators and SIU specialists, and shall be submitted to and approved by the Department within 120 days of the effective date of these rules.

2. The training programs referred to in (a)1 above shall be provided as follows:

i. In the case of automobile insurers, training shall include, but not be limited to, the following areas as appropriate: automobile theft investigations, automobile property damage and fire investigations, personal injury protection investigations, bodily injury liability claim investigation, statutory requirements for fraud referrals, techniques for the identification of fraudulent applications for coverage, insurance rate making practices, tier rating plans used by the insurer, PIP medical expense benefits and medical treatment protocols and precertification plans, and current indicators of fraud.

ii. In the case of health insurers, training shall include, but not be limited to, the following areas as appropriate: overcharging and overpayment detection, claims processing guidelines, medical coding, duplicate bills, excessive charges, unnecessary services or supplies, over-utilization, services never rendered, miscoded or misleading claim information, hospital inpatient or outpatient billing abuse or inappropriate commitment or confinement, abusive or fraudulent referrals, statutory requirements dealing with fraud referrals, techniques for the identification of fraudulent applications for coverage, the type, methods of service and operating procedures of various health insurers, and current indicators of fraud.

iii. The Basic Entry Level Training, which shall not include on-the-job training, shall be no less than 12 hours of classroom instruction. The Continuing Education Training shall be no less than 12 hours of classroom instruction per year. Basic Entry Level training shall be given to all employees within 120 days from the commencement of their employment at each of these positions: underwriters, adjusters, claims processors, SIU investigators, or SIU specialists. Persons currently employed in these positions as of (the effective date of these rules) shall be exempt from entry level training requirements.

(b) Except for insurers which insure fewer than 1,000 New Jersey automobile policies, or health insurers fewer than 10,000 lives, the plan shall provide a Fraud Prevention and Detection Procedures Manual and disseminate it to, or make it available to, as appropriate, all SIU, claims adjusters, and underwriting personnel. The Fraud Prevention and Detection Procedures Manual shall include, at a minimum, the following:

1. Information for claims adjusters, underwriting personnel, SIU investigators and SIU specialists regarding general investigation guidelines; unfair claims practices; conducting interviews; report writing; information disclosure; law enforcement relations; and the New Jersey Insurance Fraud Prevention Act;

2. The process to be employed for reporting to OIFP when specific facts and circumstances are identified, in connection with a claim or application, which upon further SIU investigation leads to a reasonable conclusion that a violation of N.J.S.A. 17:33A-4 has occurred;

3. For automobile insurers, the "fraud indicators" used for automobile theft, automobile physical damage fraud, personal injury claims fraud, bodily injury claims fraud, and application fraud;

4. For health insurers, "fraud factors" or "indicators" for health fraud, application fraud, and claims fraud;

5. The duties and functions of the SIU;

6. The procedure for referral of a claim or application to the SIU;

7. The post-referral procedure for communication between the claims unit and/or the underwriting unit and the SIU; and

8. An update page indicating that the manual has been updated and kept current.

11:16-6.6 Fraud prevention and detection plan

(a) The plan shall provide for underwriting inquiry to verify that the insured is an eligible person and the policy is properly rated within 60 days of receipt of the application. These underwriting inquiries shall verify the insured's residency provided by the insured on his or her application for insurance. The plan may provide that these inquiries are generally done "in-house" by telephone and by using information from the New Jersey Division of Motor Vehicle Services (or similar agencies in other states) and prior insurers.

(b) The following concern referral of applications and claims:

1. The plan shall provide that an application or claim shall be referred as a case to OIFP, for further OIFP investigation or other appropriate action, on the prescribed Referral Form (OIFP-1A for claims and OIFP-1B for applications, incorporated herein by reference in the subchapter Appendix), with all other information required by the form, when the investigation complies with the requirements set forth in N.J.A.C. 11:16-6.7.

2. The plan shall provide that all applications and claims, which meet the standard for referral set forth in N.J.A.C. 11:16-6.7, shall be referred to OIFP by the SIU as soon as practicable, but in no case later than 30 days from when the investigation is complete.

3. The plan shall provide criteria for the referral of automobile insurance application fraud in accordance with the requirements of N.J.A.C. 11:16-6.7.

(c) The plan shall provide that after completion of an SIU investigation, or after identification by an SIU of a pattern of applications or claims, the insurer shall provide notice to OIFP on Notification Form OIFP-2 (incorporated herein by reference in the subchapter Appendix), unless this form is superseded by an electronic reporting form, of instances in which a violation of N.J.S.A. 17:33A-4 is suspected on the basis of fraud factors or indicators, but where sufficient evidence to support a case referral pursuant to N.J.A.C. 11:16-6.7 has not been developed.

(d) The plan shall provide that all referrals of application and claims fraud and notifications of suspected application or claims fraud by the insurer to OIFP shall be made by personnel in the insurer's SIU.

(e) The plan shall provide the names and addresses of outside vendors used by the insurer to conduct investigations or perform SIU functions.

(f) The plan may include such other items as the insurer may wish to provide.

11:16-6.7 Referrals to OIFP

(a) The plan shall provide that upon completion of its investigation, as described in (d) below, an SIU shall refer cases, on form OIFP-1A or OIFP-1B, which meet the following standard to OIFP:

1. Any application or claim where the facts and circumstances create a reasonable suspicion that a person or entity has violated N.J.S.A. 17:33A-4; and

2. There is sufficient independent evidence corroborating the reasonable suspicion described in (a)1 above, from which a person could reasonably conclude that the person or entity has violated N.J.S.A. 17:33A-4.

(b) The facts and circumstances referred to in (a)1 above can include, but are not limited to, "fraud indicators" contained in an insurer's approved plan, and such other facts and circumstances as would lead a reasonable person to suspect that a violation of N.J.S.A. 17:33A-4 has occurred.

(c) As referred to in (a)2 above, independent evidence corroborating the reasonable suspicion that a person has violated N.J.S.A. 17:33A-4 includes, but is not limited to:

1. A statement from a witness;

2. Documentary evidence that directly negates a material element of the claim or directly establishes the falsity of a material element of an insurance application;

3. A report of an expert; or

4. Additional apparent misrepresentations tending to negate a possibility that the misrepresentation was merely an error.

(d) An investigation shall be complete for purposes of referral to OIFP when all reasonable and appropriate investigative leads and opportunities have been exhausted. When an investigation has identified a pattern of possible violations of N.J.S.A. 17:33A-4, the investigation will be deemed complete for purposes of referral as a case to OIFP when one or more violations included in the identified pattern have been sufficiently investigated and corroborated, in accordance with (a) above for referral to OIFP.

11:16-6.8 Record retention

(a) Insurers shall maintain up-to-date and accurate records on their fraud prevention and detection plan, which shall at minimum include those necessary to prepare the report required in (b) below.

(b) As of January 1 of each year, insurers shall submit an annual report for the prior calendar year to the Commissioner on DAFC Form #1, incorporated herein by reference in the subchapter Appendix.

1. The report referred to in (b) above shall be filed with the Department on or before February 1 of each year and sent to the following address:

New Jersey Department of Banking and Insurance
Division of Anti-Fraud Compliance
PO Box 324
Trenton, N.J. 08625-0324

2. Insurers shall submit the report referred to in (b) above in written copy and on an MS-DOS formatted disk. The disk shall be a 3.5 inch 1.44 MB disk. The information shall be provided in an Access Database provided by DAFC. Insurers may submit a disk, together with a self-addressed stamped diskette mailer to the DAFC. The DAFC will properly format the disk and return to the insurer to facilitate compliance.

3. As an alternative to the filings described in (1) and (2) above, insurers may submit this annual informational filing to the Department at the following e-mail address: dafc@dobi.state.nj.us. Insurers can acquire the required Access Database format from the Department by directing a request for the "annual filing template" to the DAFC e-mail address referenced here.

11:16-6.9 Approval and filing of fraud prevention and detection plans

(a) An insurer's fraud prevention and detection plan shall be deemed approved by the Commissioner if not affirmatively approved or disapproved by the Commissioner within 90 days of the date of filing.

(b) The Commissioner may request such amendments to the plan as he or she deems necessary.

(c) An insurer must submit amendments to its plan when necessary to achieve compliance with these rules. Any amendments to a plan filed with the Commissioner shall be deemed approved by the Commissioner if not affirmatively approved or disapproved within 90 days of the date of filing.

(d) The insurer shall permit the DAFC access to its offices upon reasonable notice and at reasonable hours to conduct an audit of the insurer's compliance with its fraud prevention plan. Nothing in this section shall be construed as to preclude the DAFC from conducting reviews of an insurer's compliance with its fraud prevention and detection plan at the office of the DAFC when determined to be necessary by the DAFC.

(e) In those instances in which an insurer uses an outside agent or contractor to adjust or investigate claims or underwrite policies, or in the case of third party administrators, the Department shall be permitted to audit the records, books and documents maintained by the outside contractor or third party administrator in the same manner and fashion as it would be able to examine the books and records in accordance with N.J.S.A. 17:33A-15 and N.J.S.A. 17:23-22.

(f) All information included in an insurer's plan submitted to the DAFC pursuant to this subchapter or any other information submitted to DAFC pursuant to this subchapter shall be confidential and not subject to public disclosure or inspection.

11:16-6.10 Penalties

Failure to comply with the provisions of this subchapter shall subject the insurer to penalties as prescribed by law.

11:16-6.11 Transition

No later than 120 days following the adoption of this subchapter, all insurers shall file with the Department a new fraud prevention and detection plan and manual in conformance with these rules.

11:16-6.12 Confidential records and information

(a) All information and materials in the possession of the Office of Insurance Fraud Prosecutor concerning the existence or occurrence of insurance fraud or related criminal activities are confidential and privileged against disclosure, and shall not be deemed public records, so as to protect the public interest in the prosecution of insurance fraud, including protecting witness security, the State's relationship with informants and witnesses, the privacy interests of persons investigated by OIFP where no fraud has been proven and other confidential relationships.

(b) The confidentiality which extends to information and materials possessed by the Office of Insurance Fraud Prosecutor with respect to the existence or occurrence of insurance fraud or related criminal activities extends to all papers, documents, reports, evidence and databases, such as investigative reports, referrals, reports or notifications of suspicious claims or applications or suspected insurance fraud, computer maintained databases of such investigative information, and such other materials and information as the Insurance Fraud Prosecutor, on the basis of his experience and exercise of judgment, believes must be kept confidential in order to ensure the orderly investigation and prosecution of insurance fraud.

(c) Confidentiality of the information and materials in the possession of OIFP shall not preclude OIFP from fulfilling its statutory obligations of working with other law enforcement agencies, the Department of Health and Senior Services, the Department of Human Services, any professional board in the Division of Consumer Affairs in the Department of Law and Public Safety, the Department of Banking and Insurance, the Division of State Police and such local government units as may be necessary or practicable and of coordinating and providing information to and among referring entities on pending cases of suspected insurance fraud, where such action would serve the public interest in facilitating the investigation or prosecution of insurance fraud.

Appendix:

Office of Insurance Fraud Prosecutor Form 1A

Office of Insurance Fraud Prosecutor Form 1B

Fraud Prevention and Detection Plan Annual Report Form